having occasional slight hemorrhage and pain, and she was repeatedly examined without the presence of hydatidiform mole in the uterus being disclosed. Finally, after nearly four weeks in the hospital, a hemorrhage of considerable size occurred, and the uterus was emptied with the curette with the patient under ether. Her convalescence also was normal.

The nature and appearance of the hydatidiform growth in all these cases was essentially the same: a large number of vesicles of various size and shape, the largest seen being about three quarters of an inch in diameter. Most of the cysts were of a light, opalescent tint, and contained a thin, light-colored fluid. Many of the cysts, however, contained blood, and consequently were dark colored, and there was also some blood on the outside, as may be seen now in the specimen. The cysts are all attached to an irregular membranous structure, the chorion, either directly or by narrow pedicles, the membrane itself being attached to the uterine surface at the placental site, and this attachment was no larger in area than that of a normal placenta of the same period. There was no evidence of fetus or of placenta in either case.

The blood supply of the growths seemed particularly small, and the hemorrhage during delivery was slight in all the cases. It seems probable that the bleeding which occurred before delivery came from the uterus at the site of the attachment and not from the breaking off of portions of the growth.

The question arises in connection with these cases, Should a positive diagnosis of cystic chorion be made? I do not believe it is possible to do so at three or four months unless some of the cysts are thrown off and are seen. Even if discharged from the uterus they may readily become occluded in clotted blood. The most prominent symptom, then, is hemorrhage, and with continued hemorrhages in the early part of pregnancy, the possibility of the presence of hydatidiform mole should be kept in mind.

In the later months of pregnancy the absence of fetal parts on careful palpation and the unusual size of the uterus, said to be present, would tend to make the diagnosis much more certain.

There is little that need be said with respect to treatment. The uterus should be emptied as soon as the diagnosis is established. Manual or instrumental dilatation to admit one or two fingers, and removal of the uterine contents with the finger, followed by the curette, is safe and efficient.

CASES OF TYPHOID FEVER SIMULATING PUERPERAL SEPSIS.

BY H. T. SWAIN, M.D.

HAVING seen a few cases of typhoid fever following immediately after delivery, which bore a most striking resemblance to cases of puerperal sepsis, it seemed worth while to speak of them, as they are not of frequent occurrence, judging from the literature. I do not mean to say that cases of typhoid developing during the puerperium are rare, but that cases coming on at once, so that a virulent sepsis is similated, are not frequently reported.

Three cases I have in mind which were so closely alike that to report one is to report all, and for that reason I will detail only one.

Mrs. N. H. entered the Boston Lying-in Hospital July 10, 1899, in labor. It was her third pregnancy, and she had been feeling, previous to the onset of labor, the same as during her former pregnancies.

She had an easy labor in the early morning of the 10th. That evening her temperature went up to 101.5°, pulse not elevated. The next morning the temperature was 102.5°, pulse 100. That evening the temperature was 104.2° and the pulse 130 of poor quality. During the day a marked diarrhea appeared, stools yellow, of pea-soup consistency, typhoidal odor. There was slight delirium. Tongue was thickly coated in the center, with red edges. There was some distension and general tenderness. Lochia and milk scanty. Inspection of the vagina and cervix negative. It was hard to tell the character of the lochia because of the continual discharges from the bowels and the fecal odor about the patient. There was present a macular eruption, which appeared and disappeared without apparent reason.

The third day there was no change in the patient's general condition except that the temperature was reduced by alcohol sponge baths and the pulse by stimulation. The diarrhea persisted and the delirium at night was present. White count 3400. No Widal. No diazo.

The fourth day rose spots appeared in abundance, the spleen was to be felt. Lochia normal in quantity and character. The diarrhea had disappeared.

The fifth day whites 3000. No Widal. Diazo present. The seventh day whites 3000. No Widal. The case was now a typical mild typhoid, from a clinical point of view. On the tenth day the Widal reaction was negative, and was not again tried for. The mother was discharged well at the end of a month. The babe was discharged well at the same time, not having been put to breast.

It will at once be seen that it was difficult to eliminate sepsis as the cause of this woman's serious condition. The temperature, taking such a sudden rise without any prodromata, is much unlike typhoid but is very like sepsis. The sudden rise of pulse and its rapid loss of character is extremely uncommon in early cases of typhoid, and is just what you would expect in a virulent sepsis. The scanty milk secretion throws no light at all on the diagnosis, because in any febrile condition the flow is diminished, especially when the baby is not put to breast. The lochia is not of help, since they may be unchanged in character and quantity in a virulent sepsis. The general abdominal tenderness with slight distension might be expected in either condition. Absence of pelvic tenderness may or may not exist in sepsis. The spleen is usually enlarged in typhoid and may be in sepsis, but is late in appearing.

Now as to diagnostic points of typhoid. First and by all odds the most important is the low white count, that is, a count way below the normal. It appears early and is certainly not an accompaniment of sepsis. The Widal reaction which appeared late in one of the cases was of no help, as it was a clear case of typhoid before that was found. Diazo reaction is of doubtful value, but may be

confirmatory. Rose spots appeared in all while there was still doubt, so that they were of help.

The prodromata may be obscured by what the patient considers the depression and discomfort of the last few days before labor, or their absence may be due to the ravages of the latent disease in a system that suddenly loses its normal resistance by the exhaustion of labor, fatigue and loss of blood.

I delivered none of the cases myself.

A CASE OF TYPHOID FEVER COMPLICATING CONVALESCENCE FROM CHILDBIRTH.

BY EDWIN P. STICKNEY, M.D., ARLINGTON, MASS.

MRS. W., a primipara, was confined at full term Sept. 7, by Dr. Alfred Worcester, in my absence. Convalescence was uneventful until Sept. 22. Previous to beginning of labor Mrs. W. had been in perfect health. At the beginning of labor her temperature was 98.8°. From this date until Sept. 22 the minimum morning temperature was 97.8° and the maximum afternoon temperature, 99.4°.

From the time of birth until the morning of Sept. 22, the patient had been unable to pass urine in the recumbent position, necessitating catheterization. The morning temperature of Sept. 22 was 99°, and the patient feeling well was permitted to sit up, and, in fact, walk to the bath-room, twenty-five feet distant. About two o'clock, after an unusually hearty dinner, the patient complained of dull pain in the region of the cecum and right uterine appendages. Temperature at 4 P.M. was 101°, with slight dull frontal headache.

Patient said she did not feel well, but aside from pain in region above mentioned could not say how, nor where she felt ill. Bowels were somewhat constipated, having moved once during the day by enema; tongue slightly coated; throat, lungs and heart negative; abdomen negative, with the exception of tenderness to pressure over the cecum, right tube and ovary, with a feeling of resistance elicited only by deep pressure; no distention of abdomen or rigidity of abdominal muscles; no vomiting or chill, and no tendency to flex the thighs on the abdomen.

On the morning of Sept. 23, after a fairly comfortable night, patient's temperature was found to be 101.7° with practically no change in condition of abdomen. The pulse was of good quality and about 90. Uterus was of normal size at the end of three weeks' convalescence, and practically no vaginal discharge. In the afternoon temperature rose to 103.6°; pulse to 104; bowels had moved fairly well, and except that patient felt more feverish there was no change in her condition. Flaxseed meal poultices to the right iliac region relieved the patient's distress without resort to drugs. Bathing with cool water and alcohol kept the patient comfortable. On the morning of Sept. 25, after a restless night, during which there had been a chill, the temperature rose to 104.9°; the headache was severe; cheeks flushed; tongue slightly coated; patient thirsty; increase of pain, tenderness and resistance on deep pressure in right iliac region; no apparent enlargement of uterus or tenderness of that organ to pressure; spleen could not be felt, but upper line of dullness was at eighth rib. Dr. Worcester saw the patient in consultation about ten o'clock in the forenoon of Sept. 25. Between eight and ten o'clock the bowels had moved freely; the pain, tenderness and resistance on deep pressure in the right iliac region had decidedly lessened, and the temperature had fallen to 101.5°.

About the slight enlargement of the spleen we were not quite certain.

An examination of the blood was deemed wise, as a further means of diagnosis, and a specimen was submitted to Dr. H. F. Hewes, of Boston, for examination.

In the afternoon of same day temperature rose to 104°, with pulse varying from 120 to 110, respiration about 20 per minute, and severe headache, which was greatly relieved by ice cap constantly to the head. Sept. 26. — The morning temperature was 100°, afternoon, 103.5°; patient felt decidedly more comfortable than on preceding day, and there were five loose, brownish-yellow movements, of foul odor, not produced by laxatives.

Report was received from Dr. Hewes stating that the blood examination was negative except for an unquestionable Widal reaction, and pronounced the case typhoid.

Sept. 27. — Highest temperature for the day 101.5°, patient feeling generally much better; bowels loose; very slight pain or tenderness in right iliac region; splenic dullness above the eighth rib, but organ could not be felt; breath decidedly bad; tongue more coated. Second examination of the blood by Dr. Hewes confirmed first report, and unquestionably established the diagnosis of typhoid fever.

Sept. 28. — Patient generally feeling better, highest temperature 99.5°, few rose spots on the abdomen.

Sept. 29. — Temperature up to 101° in the afternoon; headache returned; rose spots more numerous, and spleen unquestionably enlarged.

Oct. 1. — Yesterday afternoon temperature rose to 103.5°; this morning temperature 98.4, in the afternoon 99.5.

Patient says she feels very much better; few new rose spots on back or lower abdomen; no abdominal pain or tenderness whatever, and passes urine freely. Until present time, Oct. 21, temperature has been normal.

Oct. 21. — The patient's bowels from Oct. 1 have moved daily by enema; the convalescence has been uninterrupted, the flow of breast milk was kept up by the use of the breast pump until Oct. 10, when the baby was again put to the breast; the milk is rapidly increasing in quantity, and furnishes at present time two thirds of the quantity needed by the baby. The baby gains in weight from one to two ounces a day.

Medical Progress.

REPORT ON PEDIATRICS.

BY THOMAS MORGAN ROTCH, M.D., AND JOHN LOVETT MORSE, M.D.

TYPHOID FEVER.[1]

FIFTY-NINE and one-tenth per cent of the cases were in boys; 40.9% were in girls. There was

[1] An Analysis of Seventy-one Cases of Typhoid Fever Treated in the Children's Hospital of Philadelphia during 1901. Hand & Walker.